

## **Swing Bed Care Plan**

**Patient:** \_\_\_\_\_

**Room:** \_\_\_\_\_

Services: ( Skilled Nursing ( PT ( OT ( ST  
( Psychologist ( Dietary Consult  
( Activities ( Social Services

\*See individual Treatment/Care Plans and Team Meeting Care Plan Updates as well

Patient Strengths/Preferences:

Discharge Plan: ( Patient ( Family \_\_\_\_\_  
( Home Independent ( Home with Home Health  
( Home with someone checking in ( Home with some routine help  
( Living with a person who is: ( Home full time ( out of home for work/other  
( Assisted Living ( Long Term Care  
( Other \_\_\_\_\_

Discharge Plan Needs: ( Home Eval ( Patient Teaching  
( Caregiver Teaching ( Home Health through \_\_\_\_\_  
( Other: \_\_\_\_\_  
( Equipment: \_\_\_\_\_

DATE \_\_/\_\_/\_\_ PROBLEM: \_\_\_\_\_

TEAM GOAL/TIMEFRAME: \_\_\_\_\_

INTERVENTIONS: \_\_\_\_\_

OUTCOME: \_\_\_\_\_

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DATE __/__/__	PROBLEM:_____
TEAM GOAL/TIMEFRAME:_____	
_____	
INTERVENTIONS:_____	
_____	
OUTCOME:_____	
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OUTCOME:_____	
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_____	

### ***Signatures:***

Physician \_\_\_\_\_ \_\_/\_\_/\_\_

Patient \_\_\_\_\_ \_\_/\_\_/\_\_

Family \_\_\_\_\_ \_\_/\_\_/\_\_

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